Santa Clara County Greenbook Project

C/o Kids in Common
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A Report from the 2006 Greenbook Project Safety and Accountability Audit

How Do Our Systems Provide Safety to Families While Holding the Batterer Accountable?

March 2007

ACKNOWLEDGEMENTS

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The Safety Audit would not have been possible without the following organizations and individuals who gave us their time and insights through interviews and allowing us to observe their work:
Family Violence Center: *Jessica Welke*r
Family & Children Services: *Dunia Barron, Calvin Beckum*
Next Door Solutions for Domestic Violence: *Lupe Lucero, Erika Rivera, and Shawne Smith*
San Jose Police Department: *Sgt. Tony Colon*
Santa Clara County Dept of Family and Children's Services: *Bob Hale, Carla Macias, Priscilla Mojica, and Connie Vega*
Santa Clara County, Office of the District Attorney: *Susan Bloomfield*
Santa Clara County Probation Department: *Celeste McInerney, Justin Van*
Santa Clara County Superior Court: *Lilly Grenz, Judge Katherine Lucero, and Commissioner Shawna Schwartz,*
Support Network for Battered Women: *Lupe Lucero, Annie Martinez*
Turning Point: *Frank Del Fiugo, Carlos Ramos*

Audit text analysis would not have been possible without support from the following:
Ken Borelli, *Dept. of Family and Children's Services (Retired)*
L. Michael Clark, *Santa Clara County Office of the County Counsel*
The Honorable Leonard Edwards, *Santa Clara County Juvenile Dependency Court (Retired)*
The Honorable Katherine Lucero, *Santa Clara County Juvenile Dependency Court*

Santa Clara County
Safety and Accountability Audit

Overview

How do our systems provide safety to families while holding the batterer accountable?

BACKGROUND

In recent years, there has been a growing concern among human service providers about the co-occurrence of domestic violence and child abuse. A national survey of over 6,000 American families has shown that 50% of the men who frequently abused their wives also abused their children.[1] A second reason for concern is the demonstrated impact of domestic violence on children in the home. While primary prevention of both child abuse and domestic violence is the ideal solution, the reality is that there are many families in our community where domestic violence is present. The immediate challenge then becomes effective intervention to treat and break the cycle of violence in the family.

To that end, in 1998 the National Council of Juvenile and Family Court Judges brought together a group of national experts to write a policy blueprint to design effective interventions between child welfare services, domestic violence agencies and juvenile dependency court. The policy recommendations were published under the title "Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice." Because of its green cover, the policy manual became fondly referred to as the "Greenbook."

In January 2001 the U.S. Department of Health and Human Services funded six communities to implement the guidelines from the Greenbook under an eight federal agency, interdepartmental demonstration initiative: "Collaborations to Address Domestic Violence and Child Maltreatment." Santa Clara County was selected as one of six, nation-wide pilot sites to implement recommendations from the Greenbook.

Project oversight to this initiative was provided by senior representatives from Juvenile Dependency Court, the Department of Family and Children's Services, law enforcement and five non-profit domestic violence agencies. A larger Implementation Team met semi-annually to focus on the progress of Greenbook. This team was composed of about 70 representatives from the above agencies as well as other

[1] *Ending the Cycle of Violence- Community Responses to Children of Battered Women.* Einat Peled, Peter Jaffe, Jeffrey Edleson.

important stakeholders including representatives from mental health, probation and other community-based organizations.

The primary activities of the Santa Clara County Greenbook Project focused on increasing knowledge among professionals of the co-occurrence of child maltreatment and domestic violence and promoting change in practice and policy. Good progress was made in these areas (to see a final report go to www.kidsincommon.org/greenbook_eval). In late 2005, with the prospect that the federal funding for the Greenbook Project would end in June 2006, the Project Oversight Committee determined it was in our county's best interest to step back and take a snapshot of where we are now. This snapshot would illuminate what work still needs to be accomplished in order to improve outcomes for children and families facing domestic violence. They further determined that an audit of our systems would be the best way to understand what changes still need to be made.

METHODOLOGY

The Greenbook Project contracted with Praxis International to conduct a safety and accountability audit (Safety Audit). Praxis International has adapted a method of analysis known as institutional ethnography to the work of making legal and human service institutions more responsive to the needs of women and children. The Safety Audit is a systematic observation and analysis of work routines and documents used and produced between and among institutions as they process "cases" of domestic violence. The purpose of a Safety Audit is to see how, where and if existing practices – those that are documented in forms or policies, or those that evolve within a work culture – ensure the safety of victims and the accountability of offenders.

The Safety Audit has six distinct steps. These are:

1. Forming and preparing and inter-agency Audit Team;
2. Determining which aspects of case processing the team will investigate;
3. Determining the scope of the investigation;
4. Collecting data from each point of institutional action on a case, including the relationship between the data produced at different points of intervention;
5. Analyzing the data;
6. Preparing findings that lead to specific recommendations.

The goal of the Safety Audit is not to identify workers who are doing bad work, but instead to identify the systems' issues that impact outcomes for children and families. Audit Team members come to a practical understanding of the means by which institutions produce particular outcomes from the perspective of family safety. Team members focus on how work that is *properly done* can nevertheless produce undesirable outcomes – through the ways in which workers are institutionally organized to act on a case, are organized to conceptualize a case, and finally are coordinated with practitioners at different sites of intervention.

A FRAMEWORK FOR INQUIRY AND CHANGE

Institutions put into place methods that standardize practitioners' thinking and actions across disciplines, agencies, levels of government and job function. While they vary depending on the kinds of actions undertaken, there are eight core methods that institutions use to direct and influence workers into acting in authorized and acceptable ways. Workers in each of the systems impacting families, do not make up their jobs, but operate within a framework shaped by these methods. In order to understand how safety is provided to families while holding the batterer accountable, the Audit Team examined the following core methods that institutions use to direct and influence workers:

- **Rules and regulations:** any directive that practitioners are required to follow, such as policies, laws, memorandum of understanding, and insurance regulations.
- **Administrative practices:** any case management procedure, protocols, forms, documentary practices, intake processes, screening tools.
- **Resource issues:** practitioner case load, technology, staffing levels, availability of support services, intake processes, screening tools.
- **Concepts and theories:** language, categories, theories, assumptions, philosophical frameworks.
- **Linkages**: links to previous, subsequent, and parallel interveners.
- **Mission, Purpose and Function:** mission of the *overall process,* such as criminal law, or child protection; purpose of a *specific process,* such as establishing service plans; and, function of a worker in a *specific context,* such as the judge or prosecutor in a bail hearing.
- **Accountability:** each of the ways that processes and practitioners are organized to a) hold abusers accountable for their abuse; b) be accountable to victims and children; and, c) be accountable to other intervening practitioners.
- **Education and training**: professional, academic, in-service, informal and formal.

SANTA CLARA COUNTY'S IMPLEMENTATION

In order to formulate the audit question, consultants from Praxis worked with the Greenbook Project Oversight Committee, the Greenbook Partnership Project (a collaboration between child welfare, domestic violence advocates and others who touch the lives of children and families impacted by domestic violence) and the Greenbook Respect Culture and Community Initiative. Through a process designed by Praxis we identified the following question to answer through our audit activities:

How do our systems provide safety to families while holding the batterer accountable?

A multi-disciplinary, trained, thirteen-member Audit Team conducted this Safety Audit during the week of May 8 - 12, 2006. During that week, the team held 16 interviews (work practice and "big picture") and six observations. The interviews and observations took place in: Department of Family and Children's Services, Probation, Juvenile Dependency Court, Family Court, domestic violence agencies and shelters, as well as with batterers' intervention program providers.

Additionally, a case from the Department of Family and Children's Services was redacted and analyzed. Last, focus groups were held with children, batterers and women who were victims of domestic violence. (The women's groups were conducted in Spanish, English and South Asian Pacific speakers).

In the following months, several meetings were held with the Audit Team to develop and refine the findings and recommendations in this document. Meetings were held with key stakeholders (leadership from Probation, Department of Family and Children's Services, law enforcement and the courts) to insure that pertinent information was not left out in the development of the findings and recommendations.

RECOMMENDATIONS AND FINDINGS

On the following pages the reader will find a table of Findings and Recommendations. There were five "overarching" findings, each with sub-findings and recommendations that pertain to specific sectors or issues. Documentation to support these findings can be found in Appendix A.

Santa Clara County Greenbook Project
Safety and Accountability Question

How do our systems provide safety to families while holding the batterer accountable?

Findings – What the Safety Audit Found . . .	Recommendations – Next Steps to Address the Finding . . .
Finding 1: There are institutional guidelines in place to support the decision-making and actions taken by professionals working with families facing domestic violence. In some cases, the professional does not know these guidelines or is unable to follow them. There are some gaps in guidelines that result in decisions being left to the discretion of individual professionals.	
Finding 1a: The earlier domestic violence is identified, the better the outcomes for children & families. It is unclear if all social workers have the training, tools and resources needed to be able to readily identify and address intimate partner violence.	- Because domestic violence is present in 50-80% of child welfare cases, all social workers should have the framework to identify and document the violence. When both parties engage in violent behavior, social workers should continue to assess the underlying motivation, thoughts and beliefs of the violent acts in order to best understand what services should be offered for treatment to keep the victim and children safe. - Review recommendations made by Ann Ganley, PhD (2002) on how DFCS can implement a simpler DV assessment throughout the agency. - Ensure all guidelines and tools are kept up to date with current best practices and provide training as necessary. - Continue to decrease social worker caseload so that DV and other issues can be dealt with effectively.

Findings – What the Safety Audit Found . . .	Recommendations – Next Steps to Address the Finding . . .
Finding 1b: How domestic violence Agencies respond to victims may vary within and across agencies.	- While some variance in service delivery is guided by the needs of the individual being served, domestic violence agencies should examine whether protocols, guidelines and training are enabling their staff to best meet the needs of children. Determine if the reasons for difference in practices need to be addressed or if they make sense due to differing community needs.
Finding 1c: How law enforcement responds to victims and children experiencing domestic violence may vary within departments, by function and across agencies.	- It was not the purpose of this safety audit to address law enforcement issues. It is recommended that the Arrest Grant Safety Audit further evaluate this issue.
Finding 2: Referrals to services sometimes do not meet families' needs nor keep victims and their children safe.	

Findings – What the Safety Audit Found . . .	Recommendations – Next Steps to Address the Finding . . .
Finding 2a: Due to the complexity of governmental systems and institutions, families may not understand what is expected of them or what they need to do to satisfy their case plans. Many families need hands-on assistance to link to services and programs that will help them complete their service plans. Referrals should be made only to programs proven to support behavior change and improve outcomes for families. When more than one system is working with a client, there is not coordinated service delivery resulting in the client being unable to complete the requirements of their service plans and court orders.	- Coordinate information delivery and case management so clients are receiving a consistent message from advocates, domestic violence specialists, social workers, probation, parole and batterer treatment programs about case plan requirements and the impact of domestic violence on their case plans. - Whenever possible, when developing case plans and court orders, time constraints, financial constraints and what is really in the best interest of the client should be taken into account. - In addition to Team Decision Making meetings, encourage Multidisciplinary Team meetings to coordinate case management and support the client's success in completing his/her case plan. - Social workers, probation officers and other supportive staff need the resources to be able to spend the time needed to connect clients to services. - Consideration of the client's first language and culture is critical to case management and should be given high priority.
Finding 2b: Sometimes the services families are referred to no longer exist or do not adequately address family needs.	- Establish a method of screening and cataloguing programs for client referral to insure quality and inclusion of specific objectives and best practices to improve outcomes for children and families. - Establish a procedure to touch base with service providers to ensure services are still available and appropriate. This potentially may be addressed by the 2-1-1 system (scheduled to be launched in February 2007).
Finding 2c: The forms for Criminal Court Orders are illegible and do not easily convey the steps that need to be taken to those working with clients.	- The forms used for Criminal Court Orders should be evaluated and revised to enhance clients' ability to connect with services.

Findings – What the Safety Audit Found . . .	Recommendations – Next Steps to Address the Finding . . .
Finding 2d: Services sometimes have requirements that have unintended consequences. For example, Batterer Intervention Programs are required to have zero tolerance for ongoing battering so batterers cannot discuss such issues without dismissal from the program. Pressure to complete a case plan may place burdens on the family and lead to poor choices, financial stress and the absence of caregivers.	- The County should institutionalize the Safety Audit Process to identify other policies that may have unintended consequences and evaluate if these policies and procedures are driven by regulation, funding or other.
Finding 2e: More resources are needed to provide a variety of support to families experiencing domestic violence including childcare, employment, transportation and legal aid. Of particular concern are housing supports to victims and children. Housing support is not adequate, particularly services that provide support to victims also dealing with mental illness or substance abuse issues.	- Current resources need to be evaluated for gaps and new and/or expanded resources need to be developed to fill those gaps. - Work with domestic violence agencies, housing, Department of Alcohol and Drug Services, Mental Health, the Child Abuse Council and the Domestic Violence Council to identify additional housing needs and develop a funding plan to address those needs that include longer emergency stays and permanent housing.
Finding 3: Instead of talking with children to assess their safety, resiliency and individual needs, children are often used to gather information on parental behavior, to assess allegations of abuse and neglect or as translators for non-English speaking parents.	

Findings – What the Safety Audit Found . . .		Recommendations – Next Steps to Address the Finding . . .
	Finding 3a: The Joint Response Protocol supports law enforcement in dealing with children and has been demonstrated to improve outcomes for children by decreasing unnecessary child removals and insuring the child is interviewed in a manner that minimizes trauma. This protocol has not been fully implemented throughout the county. In some jurisdictions where it has been implemented, some officers take children to the shelter without assessment from DFCS.	- Fully implement joint response protocol throughout the county. - Identify and educate officers who are not following the joint response. - Evaluate and if necessary, revise the DV protocol to include information about working with children when DV is present.
	Finding 3b: Child welfare social workers gather information on resiliency and the child's distinct individual characteristics such as favorite toys, interests, likes and dislikes. However, the focus of many of the forms used to document a child's welfare when domestic violence is present portrays the child as a witness to domestic violence. These forms do not provide a standardized manner to record this information about the child.	- Develop a standardized method (tool, form, and computer data collection) that will allow social workers to record information already gathered on children that now does not make it into the child's permanent record. Information that is being gathered and should be recorded include the child's individuality, needs, interests and resiliency factors, allowing the social worker to make better decisions for the child, particularly when a case is moved from one social worker to another. Ensure this new tool is simple to use and does not add significantly to the worker's workload. Train social workers as needed.
Finding 4: Standardized practices, tools, protocols and resources need to be expanded and fine tuned to hold batterers accountable and insure the safety of the child. Adult victims of domestic violence have the right to be provided with tools such as safety planning and education which may help keep themselves and their children safe and information about their legal obligations to their children.		

Findings – What the Safety Audit Found . . .	Recommendations – Next Steps to Address the Finding . . .
Finding 4a: Child welfare social workers work with involuntary clients who do not readily understand how their behaviors adversely impact their children. Child maltreatment cases with intimate partner violence are particularly challenging to child welfare social workers in that the system does not have the tools to hold any offending parent accountable for child maltreatment or intimate partner violence.	- Tools and training are needed for social workers to help the biological parent who is the dominant aggressor understand how their behavior impacts their children and the important role they play in their children's lives. Tools are also needed to work with dominant aggressors who are not the biological parent. - Identify best practice and tools to hold batterer accountable and institutionalize their use at DFCS. Consider bringing in an expert consultant to work with the department to enhance protocols and provide additional training for social workers if needed. - All systems need to understand and recognize that batterer's may choose to not participate in programs. In these cases, (primarily child welfare cases) education, resources and support for the adult victim to maintain safety for self and family must be in place.
Finding 4b: Emergency Protection Restraining Orders can be issued to protect the child from the batterer but are not used as often as would be expected when compared to the frequency of cases.	- A committee should explore why EPROs are not being utilized more frequently. This committee should explore the following issues: 1. Unintended consequences of EPRO's. 2. The reasons why some victims do not want or support the issuance of an EPRO 3. Resource issues that may make it difficult for the police officer to issue an EPRO 4. The parameters that guide Law Enforcement re: Issuance of EPROS. 5. Training needs of Law Enforcement re. their obligations re. Issuing EPROS 6. Alternatives for cases where Law Enforcement wants to issue an EPRO and the victim refuses.

Findings – What the Safety Audit Found . . .	Recommendations – Next Steps to Address the Finding . . .
Finding 4c: There is poor communication between the Probation and Batterers' Intervention Programs (BIPs), DFCS and victims. When a BIP identifies an issue with a batterer, the channels of communication with probation are not always effective largely due to a lack of resources. Batterer has a 30-day period to enroll in a BIP, but there are often no consequences when enrollment does not occur in that timeframe. (Cases are referred back to court when the safety risk is high.) A variety of issues make victim notification regarding a batterer's status difficult. (Sometimes victim's contact info is not available.)	- Convene a working group including Probation, the Courts, batterer intervention programs and the Department of Family and Children's Services to clarify roles, administrative practices and how to support the systems working together effectively. - Develop policy for communication and feedback between BIPs, Probation, DFCS, the victim, District Attorney's Office and the Courts. - Evaluate the effect of caseload on probation workers and ability to follow-up with DFCS and Victims when batterers do not complete programs. - Evaluate the feasibility of reinstating the offering of Batterer Intervention Programs in the jail setting. - Identify resource needs to allow professionals working with batterers the ability to support the completion and follow-through of case plans and court orders. - Evaluate the feasibility to include Probation Officers in child welfare Team Decision Making meetings when appropriate. - Law enforcement and probation officers should collect victim cell phone numbers and other alternative numbers for easier contact. - Work with Superior Court to support the Criminal Domestic Violence case manager which may help increase batterer accountability by improving communication across systems, enrollment in Batterer Intervention Programs, contact with victims, etc.

Finding 5: Language spoken by the family seems to impact the initial entry into systems serving families impacted by domestic violence and services received by those families.		
	Finding 5a: Language spoken by the family may be impacting identification of DV (Spanish and Vietnamese and indigenous languages). • Children, friends and neighbors are sometimes utilized as translators during domestic violence incidents. This may lead to manipulation of information given to the officer or undue stress on the child. • "Over the phone" translation service is not utilized • In many languages, domestic violence does not exist as a concept and translation alone may not support effective handling of the situation.	- Revise the Domestic Violence Protocol for Law Enforcement to advise officers that children should never be used as interpreters at the scene when interviewing victims or perpetrators. The protocol should also advise against using other family members and neighbors to interpret, as information given to the officer in these situations can be manipulated and unreliable. - Offer support and resources to expand the Domestic Violence Advocacy Consortium's Language Bank to serve broader need. - Identify difficulties using "over the phone" or language lines for interpretation services. Provide training to improve officers ability to utilize this service and research other models of interpretation services provided in other communities. - Certified professional interpreters need training on domestic violence.
	Finding 5b: Many service referrals are not offered in Spanish, Vietnamese and other languages needed by families in order to support successful completion and behavior change.	- Identify service needs and develop programs in needed languages. - Develop a system to update and provide accurate information on services available and languages provided.

Appendix

How the Findings Were Identified

Each of the findings of the Safety Audit were identified through interviews, case analysis, focus groups or observation. How the finding was identified is explained on the table below. Additionally, the core methods that impact each finding are identified on this table.

Finding	How the Finding was Identified	Core Method(s) that Impact the Finding:
Finding 1a: The earlier DV is identified, the better the outcomes for children & families. It is unclear if all social workers have the training, tools and resources needed to be able to readily identify and address intimate partner violence.	This finding arose from interviews team members conducted with DFCS staff and with interviews and observations of social workers. This issue came up through the text analysis. Text reviewed included the forms social workers used to document their investigations and contact with the family as well as the laws and regulations governing their work. The issue was then raised during several audit team debriefings.	- Administrative Practices - Resources - Education and Training
Finding 1b: How domestic violence Agencies respond to victims may vary within and across agencies.	This finding arose from interviews team members conducted with staff at the various domestic violence shelters and a review of their protocols for assisting victims who call the hotline. This was also discussed during the audit team debriefings.	- Administrative Practices - Education and Training
Finding 1c: How law enforcement responds to victims and children experiencing domestic violence may vary within departments, by function and across agencies.	This issue came up time and time again during four focus groups involving battered women and children. This also came up in an interview with a batterer. Although this was not examined any further the audit team felt this issue arose so often in these groups that it should be noted.	- Administrative practices - Resources - Education and Training
Finding 2a: Sometimes clients do not understand what they need to do to satisfy their case plans. Many families need hands-on assistance to link to services and programs that will support behavior change and the completion of their service plans and court orders.	This issue arose in team interviews with social workers, other DFCS staff as well as in interviews and observations with probation officers and domestic violence advocates interviewed. This also arose out of the three focus groups conducted with battered women. The audit team discussed finding in great detail.	- Resources - Linkages - Mission, purpose and function - Education and Training

Finding	How the Finding was Identified	Core Method(s) that Impact the Finding:
When more than one system is working with a client, there is not coordinated service deliver resulting in the client being unable to complete the requirements of their service plans and court orders.	This issue came up in interviews with DFCS social workers, in team observations with social workers and with probation officers as well as in interviews with probation officers. The audit team discussed this finding in great detail as well.	
Finding 2b: Sometimes the services families are referred to no longer exist or do not adequately address family needs.	This issue came up in the three focus groups with battered women, in interviews with domestic violence advocates at various programs, with DFCS staff and social workers, with probation officers and with court personnel. This was raised in audit team debriefings as well.	- Resources - Linkages - Accountability
Finding 2c: Criminal Court Order forms are illegible and do not easily convey to those working with clients the steps that need to be taken.	This issue came up in interviews with Probation and batterer intervention staff. This was raised in audit team debriefings as well.	- Administrative Practices - Linkages
Finding 2d: Services sometimes have requirements that have unintended consequences. For example, Batterer Intervention Programs are required to have zero tolerance for ongoing battering so batterers cannot discuss such issues without dismissal from the program. Pressure to complete a case plan may place burdens on the family and lead to poor choices, financial stress and the absence of caregivers.	This arose in the interviews with batterer intervention staff. This also came up and was discussed in the audit team debriefings.	- Rules and Regulations - Administrative Practices - Linkages
Finding 2e: More resources are needed to provide a variety of support to families experiencing domestic violence including childcare,	This arose from the focus groups with battered women, interviews and observations with domestic violence advocates and interviews and observations with DFCS staff. This was	- Resources - Education and Training

Finding	How the Finding was Identified	Core Method(s) that Impact the Finding:
employment, transportation and legal aid. Of particular concern are housing supports to victims and children. Housing support is not adequate, particularly services that provide support to victims also dealing with mental illness or substance abuse issues.	raised in the audit team debriefings as well.	
Finding 3a: The Joint Response Protocol supports law enforcement in dealing with children and has been demonstrated to improve outcomes for children by decreasing unnecessary child removals and insuring the child is interviewed in a manner that minimizes trauma. This protocol has not been fully implemented throughout the county. In some jurisdictions where it has been implemented, some officers take children to the shelter without assessment from DFCS.	This arose as an issue from the focus groups with battered women and with children. This also came up in the interview of SJPD staff as well as in the observations and interviews of DFCS staff. This was raised in team debriefings and further discussed.	- Administrative Practices - Resources - Linkages - Education and Training
Finding 3b: Child welfare social workers gather information on resiliency and the child's distinct individual characteristics such as favorite toys, interests, likes and dislikes. However, the focus of many of the forms used to document a child's welfare when domestic violence is present portrays the child as a witness to domestic violence. These forms do not provide a standardized manner to	This arose from the text analysis. The text included a case pulled and redacted for review by the team as well as an analysis of the forms used to document the investigation of a case of child abuse. This was discussed in great detail by the audit team in the debriefings.	- Administrative Practices - Resources - Education and Training

Finding	How the Finding was Identified	Core Method(s) that Impact the Finding:
record this information about the child.		
Finding 4a: Child welfare social workers work with involuntary clients who do not readily understand how their behaviors adversely impact their children. Child maltreatment cases with intimate partner violence are particularly challenging to child welfare social workers in that the system does not have the tools to hold any offending parent accountable for child maltreatment or intimate partner violence.	This arose from a number of sources during the audit week including the following: the observations and interviews with DFCS staff, court personnel and Domestic violence advocates. This was also discussed by the audit team.	- Administrative Practices - Resources - Education and Training
Finding 4b: Emergency Protection Restraining Orders can be issued to protect the child from the batterer but are not used as often as would be expected when compared to the frequency of cases.	This came up from interviews and observations in dependency court. This also came up from a review of the laws and regulations governing EPRO's. This was also discussed by the audit team during debriefings.	- Administrative Practices - Resources - Linkages - Accountability - Education and Training
Finding 4c: There is poor communication between the Probation and Batterer's Intervention Programs (BIP's), DFCS and victims. When a BIP identifies an issue with a batterer, the channels of communication with probation are not always effective largely due to a lack of resources. Batterer has a 30-day period to enroll in a BIP, but there are often no consequences when enrollment does not occur in that timeframe.	This arose from interviews with Batterer Intervention program staff. This was also raised and discussed in audit team debriefings.	- Administrative Practices - Resources - Linkages - Mission, Purpose and Function - Accountability - Education and Training

Finding	How the Finding was Identified	Core Method(s) that Impact the Finding:
(Cases are referred back to court when the safety risk is high.) A variety of issues makes victim notification regarding a batterer's status difficult. (Sometimes victim's contact info is not available.)		
Finding 5a: Language spoken by the family may be impacting identification of DV (Spanish and Vietnamese and indigenous languages). • Children, friends and neighbors are sometimes utilized as translators during domestic violence incidents. This may lead to manipulation of information given to the officer or undue stress on the child. • "Over the phone" translation service is not utilized • In many languages, domestic violence does not exist as a concept and translation alone may not support effective handling of the situation.	This issue arose from each of the focus groups conducted. It also came up in interviews with social workers and advocates in court. This was also discussed in great detail by the team in audit debriefings.	- Administrative Practices - Resources - Linkages - Education and Training
Finding 5b: Many service referrals are not offered in Spanish, Vietnamese and other languages needed by families in order to support successful completion and behavior change.	This arose almost everywhere in our interviews throughout the system DFCS, Domestic Violence, focus groups, BIP, Probation and the courts. This was also discussed in great detail at audit team debriefings.	- Resources - Linkages